Employment Verification

PART I: To be completed by applicant. Complete this part and submit a copy to each place you were employed during the last two years.

Applicant Name:_____ SS#:_____

Address:_____

Name of hospital or agency: _____

I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Nursing.

Applicant Signature:_____ Date:_____

PART II: To be completed by employer. All verifications shall be mailed *directly* from the employer and *must* include the following criteria:

- Typed on official agency letterhead with an original signature
- Applicant Name
- Is employment at a nursing home, hospital, home health agency, hospice agency, or mental health facility?
- Address of employer to include: mailing address, city, state and zip code
- Employer's telephone number to include: area code and number
- Printed name of verifying agent
- Signature of verifying agent and date completed
- Start and End dates of employment (month and year)
- Did the applicant work for monetary compensation?
- Did the applicant work as a nurse aid, performing direct patient care?
- Did the applicant work under the supervision of a registered nurse?

Complete verifications must be mailed directly from the verifying agency to:

Florida Board of Nursing
4052 Bald Cypress Way
Bin # C13
Tallahassee, Fl 32399-3252